STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	CONSTRUCTION	(X3) DATE S COMPLI		
			A. BOILDING.			
		005072	B. WING		04/2	0/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
FRANCIS	CAN HEALTH RENSSEL	AER, INC RENSSE	RACE ST _AER, IN 47978	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
	This visit was for a St survey.	ate hospital licensure				
	Dates: 4/18/2016 to 4	4/20/2016				
	Facility Number: 005	072				
	QA: cjl 05/11/16					
S 320	410 IAC 15-1.4-1 GO	VERNING BOARD	S 320			5/31/16
	410 IAC 15-1.4-1(c)(6	8)(G)				
	(c) The governing board for managing the hos governing board shall following: (6) Require that the cofficer develops policifor the following:	pital. The look the l				
	(G) Providing employ and a post offer physi in consultation with th control committee.	ical examination,				
	governing board failed a post offer physical ed with the infection contaccordance with facility	eview and interview, the d to ensure the provision of examination in consultation				

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

06/17/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED	
AND FLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		-LETED
		005072	B. WING		04	/20/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ED ANGIO	CAN LIE AL TIL DENGGEL	1104 E (RACE ST			
FRANCISC	CAN HEALTH RENSSEL	RENSSE	LAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 320	Continued From page	e 1	S 320			
	1. Policy #AM-IV-1, E Requirements, revise indicated on pg. 1, un Requirements, point are required prior to F employees beginning	Employee Health d/reapproved on 8/15/13 nder Employment 1. c., physical examinations Personnel Orientation for all May 4, 2010the erformed by a Family Nurse				
	2. Review of personne personnel: A. N5, was hired 12 documentation of a prexamination. B. N12, was hired 1 documentation of a prexamination. C. N13, was hired 9 documentation of a prexamination. D. N14, was hired 9 documentation of a prexamination. E. N16, was hired 9 documentation of a prexamination. F. N17, was hired 9 documentation of a prexamination. G. N18, was hired 9 documentation of a prexamination. H. N19, was hired 1 documentation of a prexamination. I. N20, was hired 9 documentation of a prexamination. I. N20, was hired 9 documentation of a prexamination.	2/13 and lacked ost offer physical 2/20/15 and lacked ost offer physical 2/1/15 and lacked ost offer physical 2/20/15 and lacked ost offer physical				
	documentation of a person examination. I. N20, was hired 9/	ost offer physical 1/15 and lacked ost offer physical				

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 2 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SI COMPLE		
			A. BUILDING:			
		005072	B. WING		04/2	0/2016
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
FRANCISC	CAN HEALTH RENSSEL	AER. INC	RACE ST LAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
S 320	Continued From page	2	S 320			
	documentation of a person of a					
	Health) was interview approximately 1010 h Employee Medical Hi completed and signed Post offer physical ex completed for person	ours and confirmed only an				
S 406	410 IAC 15-1.4-2 QU IMPROVEMENT	ALITY ASSESSMENT AND	S 406			6/3/16
	410 IAC 15-1.4-2(a)(1)				
	(a) The hospital shall effective, organized, homographic comprehensive qualit improvement program of the hospital particip program shall be ong written plan of implemevaluates, but is not be following:	nospital-wide, y assessment and n in which all areas pate. The oing and have a nentation that				
	(1) All services, include furnished by a contract	_				
	hospital failed to ensu (Electroencephalogra Therapy, Biohazard V Security) of six service	review and interview, the				

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 3 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		005072	B. WING		04/2	0/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
FRANCISC	CAN HEALTH RENSSELA	AER, INC 1104 E GR RENSSEL	ACE ST AER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 406	Continued From page	3	S 406			
	program.					
	Findings included:					
	Improvement Program Quality Plan shall be a comprehensive and c Hospital Board of Trus administration, depart monitor and improve to	ssurance & Performance In Plan indicated "The Identificated, Identificated, Identificated, Identificated, Identificated, Identificated, Identificated Identi				
	Safety committee das 2015 indicated the do lacked documentation the following services Pediatrics, Infusion Th Hauler, Laundry and S	0 PM on 4/19/20176, staff Quality Management) /e and no other				
S 418	410 IAC 15-1.4-2 QUA	ALITY ASSESSMENT AND	S 418			6/3/16
	410 IAC 15-1.4-2(b)(1)(2)				
	(b) The hospital shall appropriate action to a opportunities for improthrough the quality as improvement program	address the ovement found sessment and				

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 4 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_			
		005072	B. WING		04	/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
FRANCIS	CAN HEALTH RENSSELA	AER. INC	RACE ST LAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S 418	Continued From page	2 4	S 418			
	(1) The action shall be	e documented.				
	(2) The outcome of the documented as to its continued follow-up a patient care.	effectiveness,				
	hospital failed to docu address the opportun (blood bank, dietary, anewthesia and infec	review and interview, the ument an action plan to ities for improvement for 5 nursing medical/surgical, tion control [Wound]) of 5 al's quality assessment and				
	Findings included:					
	Improvement Program departments and tear performance indicator	ssurance & Performance m Plan indicated "All ms are required to submit r information in a timely terly." The QAPI Plan was				
	program dashboards	res of the hospital's QAPI indicated there was no ction plans for areas that fell				
	criteria targeted goal quarter of 2015, the h target. The departme documented remedia deficiencies.	arts meeting transfusion was 100% and in the 4th cospital only met 96% of the ent dashboards lacked I action to address safety & sanitation audit				

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 5 of 18

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		
		005072	B. WING	· · · · · · · · · · · · · · · · · · ·	04/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
FRANCIS	CAN HEALTH RENSSELA	AER. INC	RACE ST LAER, IN 47978		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 418	monitors are being pr goal was 100% and ir the hospital only met department dashboar remedial action to add. C. Nursing Medical/education aligns with targeted goal was 100 2015, the hospital onl The department dash remedial action to add. D. Anesthesia - Pre completed and signed 98% and in the 1st quonly met 80% of the transport of the total dashboards lacked do to address deficiencies. E. Infection Control admitted from Emerget targeted goal was 100 2015, the hospital onl The department dash remedial action to add.	acticed. Criteria targeted in the 4th quarter of 2015, 87% of the target. The ds lacked documented dress deficiencies. Surgical - Medication primary diagnosis criteria 20% and in the 4th quarter of y met 68% of the target. boards lacked documented dress deficiencies. /Post assessment di criteria targeted goal was larter of 2016, the hospital larget. The department ocumented remedial action iss. (Wound) - Documented on ency Department criteria 20% and in the 4th quarter of y met 17% of the target. boards lacked documented dress deficiencies. 0 PM on 4/19/20176, staff Quality Management) ye and no other	S 418		
S 754	410 IAC 15-1.5-4 ME SERVICES	DICAL RECORD	S 754		5/16/16
	410 IAC 15-1.5-4(f)(5)			
	(f) All inpatient record those in subsections				

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 6 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		005072	B. WING		04/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
FRANCIS	CAN HEALTH RENSSELA	AER, INC 1104 E GF RENSSEL	ACE ST AER, IN 47978		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
S 754	Continued From page document and contain to, the following: (5) Evidence of approcessory consent for procedure for which it is required by the informed consedeveloped by the med governing board, and federal and state law. This RULE is not medical and state law. This RULE is not medical record facility failed to ensure informed consent for apatient medical record Findings: 1. Policy #NS-29, Hed Management: Consedent Anesthetics, and Other revised/reapproval 2/1 under Procedure sectin patients and outpatients and outpatients.	priate informed s and treatments I as specified ent policy dical staff and consistent with It as evidenced by: eview and interview, the exproperly executed 2 of 4 (9 and 12) surgical dis reviewed. alth Information ont to Operation(s), er Medical Services, 12/16, indicated on pg. 1, ion, "To be filled out for all ents who are to have any y. Must be signed before	S 754	DEFICIENCY)	
	patient: A. 9 underwent a su and Surgical Consent physician's signature. B. 12 underwent a s	surgical procedure on Consent lacked the time of			

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 7 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1		(X3) DATE S COMPL	
	005072	B. WING		04/2	20/2016
OVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
AN HEALTH RENSSELA	AER. INC	_			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETE DATE
3. Staff 19 (Health Inwas interviewed on 4/1300 hours, and corabove-mentioned patiphysician signed the storms need to be sign patient (if able) and the	formation Management) (18/16 at approximately infirmed the tients lacked the time the Surgical Consent and these led, dated, and timed by the lie witness and the physician	S 754			
SERVICES 410 IAC 15-1.5-7 (d)(2) (d) Written policies an shall be developed and that include the follow (2) Ensure the monthly all areas where drugs are stored and which not limited to, the follow (B) Appropriate storage This RULE is not mere Based on observation interview, the facility for storage conditions for facility policy and proceed procedures to be partment) areas to be served.	2)(B) Ind procedures and implemented imp: By inspection of and biologicals address, but are owing: By conditions. It as evidenced by: By document review and ailed to ensure appropriate amedications according to be dure for 1 of 7 (Surgery by Carlotte and Carlotte).	S1022			4/21/16
	SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page 3. Staff 19 (Health Interpretation of the start of the	DOSOT2 DOVIDER OR SUPPLIER AN HEALTH RENSSELAER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 3. Staff 19 (Health Information Management) was interviewed on 4/18/16 at approximately1300 hours, and confirmed the above-mentioned patients lacked the time the physician signed the Surgical Consent and these forms need to be signed, dated, and timed by the patient (if able) and the witness and the physician prior to the start of the procedure. 410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure appropriate storage conditions for medications according to facility policy and procedure for 1 of 7 (Surgery Department) areas toured. Findings: 1. Policy #PH-41, High Risk or High Alert Medications, revised/reapproved on 3/31/13	DOUDER OR SUPPLIER STREET ADDRESS, CITY, STATE, AN HEALTH RENSELAER, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 3. Staff 19 (Health Information Management) was interviewed on 4/18/16 at approximately -1300 hours, and confirmed the above-mentioned patients lacked the time the physician signed the Surgical Consent and these forms need to be signed, dated, and timed by the patient (if able) and the witness and the physician prior to the start of the procedure. 410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure appropriate storage conditions for medications according to facility policy and procedure for 1 of 7 (Surgery Department) areas toured. Findings: 1. Policy #PH-41, High Risk or High Alert Medications, revised/reapproved on 3/31/13	DIVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 3. Staff 19 (Health Information Management) was interviewed on 4/18/16 at approximately -1300 hours, and confirmed the above-mentioned patients lacked the time the physician signed the Surgical Consent and these forms need to be signed, dated, and timed by the patient (if able) and the witness and the physician prior to the start of the procedure. 410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure appropriate storage conditions for medications according to facility policy and procedure for 1 of 7 (Surgery Department) areas toured. Findings: 1. Policy #PH-41, High Risk or High Alert Medications, revised/reapproved on 3/31/13	DOMORCO RECTION DIDENTIFICATION NUMBER: 005072 STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 17978 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUST BE PRECEDED BY FULL REGULATORY OR I.S. (IDENTIFYING INFORMATION) 2 3. Staff 19 (Health Information Management) was interviewed on 4/18/16 at approximately -1300 hours, and confirmed the above-mentioned patients lacked the time the physician signed the Surgical Consent and these forms need to be signed, dated, and timed by the patient (if able) and the witness and the physician prior to the start of the procedure. 410 IAC 15-1.5-7 (d)(2)(B) (d) Written policies and procedures shall be developed and implemented that include the following: (2) Ensure the monthly inspection of all areas where drugs and biologicals are stored and which address, but are not limited to, the following: (B) Appropriate storage conditions. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure appropriate storage conditions for medications according to facility policy and procedure for 1 of 7 (Surgery Department) areas toured. Findings: 1. Policy #PH-41, High Risk or High Alert Medications, revised/reapproved on 3/31/13

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 8 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		005070	B. WING			10010040
		005072			04	/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
FRANCIS	CAN HEALTH RENSSEL	AER. INC	RACE ST LAER, IN 47978			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE
S1022	Continued From page	e 8	S1022			
	v., employees will be medications. These r sequestered and sep medication inventory reduce errors. Pharm auxiliary (High-alert) storage bins containing. B. 4, Appendix A: MedicationsZemero. 2. While on tour of fa approximately 1328 r 10 (Director of Opera Care Unit/Central Stere Reprocessing/Outpat medication of Zemero stored separately from inventory or in a bin of sequences.	medications will be parated from the general in a system that would pacy will apply special marning labels on the mg high-alert medications. High-Alert on (rocuronium). Acility on 4/18/16 at mours, accompanied by staff atting Room/Post Anesthesia				
C4440	Anesthesia Care Unit Reprocessing/Outpat interviewed on 4/19/1 hours and confirmed risk/high alert medica according to policy.	tient Department) was 16 at approximately 1328 the above-mentioned high ation was not stored	04440			0/07/40
S1118	410 IAC 15-1.5-8 PH	YSICAL PLANT	S1118			6/27/16
	410 IAC 15-1.5-8 (b)((2)				
	(b) The condition of the plant and the overall environment shall be maintained in such a safety and well-being	hospital developed and manner that the				

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 9 of 18

Indiana State Department of Health

l l	BUILDING:		COMPLETED
005072 B. W	WING		04/20/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS,	S, CITY, STATE, ZIP C	CODE	
FRANCISCAN HEALTH RENSSELAER, INC 1104 E GRACE S RENSSELAER, I			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. This RULE is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure no condition was created or maintained that may result in a hazard to patients, visitors, and/or employees regarding the floor landing above the steps that lead to the basement of Fitness off-site being uneven, off-site storage room located in the basement being heavily cluttered, off-site Therapy Department with assorted fitness equipment stored in the patient restroom, off-site with at least six ceiling light fixtures with their light shielding cracked, broken and missing section of the plastic light cover, hospital Laundry Department folding room ceiling paint chipping and peeling directly above shelves of uncovered folded assorted linen items and without an eyewash station, blanket warmer temperatures being above facility policy guideline for 3 of 3 (Outpatient Department, Medical/Surgical Department and Oncology Department) areas toured; and related to Soiled Utility Rooms not being locked in 5 of 7 (Outpatient/Inpatient Surgical Departments, Medical/Surgical Department, Oncology Department, Alterna Care Extended Care Department) areas toured; and related to clean supplies being stored in Soiled Utility rooms in 2 of 7 (Emergency Department [ED] and Outpatient Surgical Pre/Post Department) areas toured. Findings included:	1118		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		005072	B. WING		04	1/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		
FRANCIS	CAN HEALTH RENSSELA	AER, INC 1104 E GI RENSSEL	ACE ST AER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S1118	safety rules and precato provide a safe envito our care, as well as employed at our facility visit have been listed assist in providing a senvironment." Francisafety Plan was last in 2. At 9:13 AM on 4/2 above the steps that I Franciscan Health an observed to be unever the uneven floor surficarpet flooring. 3. At 9:15 AM on 4/2 Health and Fitness of in the basement adjact courts was observed for easy access to as room was observed willed storage boxes at 4. At 9:20 AM on 4/2 Health and Fitness of patient restroom was fitness equipment stop presented uneasy accent and washing sink and 5. At 9:30 AM on 4/2 and Fitness off-site will ceiling light fixtures will cracked, broken and plastic light cover. 6. At 11:20 AM on 4/2	ety Plan indicated "Those autions that will be required ronment for those entrusted is to all of those who are ity and to those who may. It is necessary for you to safe and healthful scan Healthcare Rensselaer revised June 11, 2013. 0/2016, the floor landing lead to the basement of it of Fitness off-site was an and posed a trip hazard. Face was visible under the item of the racquetball heavily cluttered and unsafe sorted equipment. The with sporting equipment, and maintenance tools. 0/2016, the Franciscan fesite Therapy Department observed with assorted red in the restroom that cleast to the patient's ith their light shielding missing section of the item of the section of the indicated in the hospital indicat	S1118			
		folding room ceiling paint				

Indiana State Department of Health

STATE FORM STATE FORM If continuation sheet 11 of 18

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		005072	B. WING		04/20/2016
NAME OF D	ROVIDER OR SUPPLIER		DDESS CITY STA	TE ZID CODE	1 04/20/2010
NAME OF P	ROVIDER OR SUPPLIER	1104 E GF	DRESS, CITY, STA	I E, ZIP CODE	
FRANCIS	CAN HEALTH RENSSELA	AER. INC	AER, IN 47978		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
S1118	Continued From page	e 11	S1118		
		hipping and peeling directly overed folded assorted linen			
	member #1 (Director	5 PM on 4/20/2016, staff of Operations) confirmed all er documentation was			
	4/19/16 at approximal accompanied by staff Services), it was observices warmer temperatures degress Fahrenheit a station located in the Sterile and Reprocess Maintenance Departments of the Sterile and Reprocess Maintenance Departments of the Sterile and Reprocess Maintenance Departments of the Sterile and Reprocess of the Sterile and Reprocessing the Sterile and Reprocessing of t	ximately 1455 hours and tely 1255 and 1426 hours, 13 (Director of Patient Care erved that the blanket ranged between 134-138 and there was no eyewash dirty side of the Central sing room or the ment. The nearest eyewash the laundry room, which 00 feet away through 3 and right turns. It was a tion with 2 bottles of			
	cleaning head wound and unused trash can shelving in the ED So instruments are being this room as well. (2). new Sani-Clot stored in closed cabir	of a large plastic tray for s and toilet paper, tissues in liners were stored on open wiled Utility Room and soiled in high-level disinfected in the wipe containers were nets in the Outpatient partment Soiled Utility			

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		I \ /	(X3) DATE SURVEY COMPLETED	
		005072	B. WING		04	/20/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
FRANCIS	CAN HEALTH RENSSELA	AER. INC	RACE ST LAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S1118	(3). Soiled Utility R Outpatient/Inpatient S Medical/Surgical Dep Department and Alter Department and conta containers and used I 9. Policy #MNT, Eyer revised/reapproved or eyewash stations must basis to insure proper adequately flush the et 10. Policy #IC-26, Inv Maintenance of Supp and Food, revised/rea on pg. 1, point II.F., cl and supplies are to be equipment. 11. Policy #IC-11 Infe Waste/Refuse, revise indicated on pgs. 1 ar infectious waste is ca dangerous communic includes but is not lim or objects that could p contaminated sharps, spikesdepartment s prior to pick-up by En be stored in a secure the general public. 12. Staff 10 (Director Anesthesia Care Unit Reprocessing/Outpat interviewed on 4/18/1 hours and confirmed temperatures have be	Rooms were unlocked in the Burgical Departments, artment, Oncology and Care Extended Care ained used sharps biohazardous bags. Wash Stations, an 9/1/15 indicated the set be checked on a regular adelivery of water to eyes of personnel. Wentory, Cleaning, lies, Equipment, Medication approved on 8/14 indicated lean or sterile equipment are stored separate from dirty. Pectious Waste/Medical d/reapproved on 8/14 and 2, points 1.a. and 3.b., pable of transmitting able diseases. This ited to contaminated sharps botentially become such as IV (intravenous) trorage of infectious waste vironmental Services shall area to prevent access by Tof Operating Room/Post //Central Sterile & ient Department) was 6 at approximately 1500 blanket warmer	S1118			

Indiana State Department of Health

STATE FORM STATE FORM If continuation sheet 13 of 18

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
005072		B. WING	B. WING		04/20/2016		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	1 04/2	0/2010	
FRANCIS	CAN HEALTH RENSSELA	AER. INC	RACE ST LAER, IN 47978				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
S1118	Continued From page 13 procedure. The eyewash station located in the laundry room had expired eyewash solution. Additionally, Soiled Utility Rooms are not being locked as required per facility policy and procedure, and clean supplies should not be stored in Soiled Utility Rooms to prevent transmission of dangerous communicable diseases.		S1118				
\$1160	facility failed to ensure working order and reg maintained for 1 of 1 equipment observed. Findings: 1. Review of letter re related to cryostat con has completed the prosection, the Cryostat tissue/OCT fragments	quirements are as If be in good gularly serviced It as evidenced by: eview and interview, the e all equipment is in good gularly serviced and (Cryostat) piece of Vised/reapproved 12/22/14 of irmed once the pathologist	S1160			6/2/16	

Indiana State Department of Health

STATE FORM 6899 XYH411 If continuation sheet 14 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		005072	B. WING		04/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
FRANCIS	CAN HEALTH RENSSEL	AER. INC	RACE ST LAER, IN 47978		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S1160	2/22/16 and a frozen using the Cryostat. B. 14 underwent as 2/22/16 and a frozen using the Cryostat. 3. Review of Cryostat confirmed it was insp 10/22/15. 4. Staff 10 (Director of Anesthesia Care Unit Reprocessing/Outpat interviewed on 4/19/1 hours and confirmed	surgical procedure on section was processed surgical procedure on section was processed at maintenance Logs ected/cleaned last on of Operating Room/Post	S1160		
S1162 410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule.		S1162		6/3/16	

Indiana State Department of Health

STATE FORM STATE FORM If continuation sheet 15 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		005072	B. WING		04	/20/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FRANCIS	CAN HEALTH RENSSELA	AER. INC	RACE ST LAER, IN 47978				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE	
S1162	Continued From page 15		S1162				
	This RULE is not met as evidenced by: Based on document review and interview, the hospital failed to ensure 7 (hydrocollator, scrubber, air handler, 3 wheelchairs and cryostat) of 7 pieces of equipment had preventive maintenance inspections per manufacturer recommendations. Findings included: 1. Review of the Operation Manual instructions for M-2 Master Heating Hydrocollator Unit indicated, "The thermostats are extremely sensitive and the slightest adjustment will alter the temperature several degrees. The recommended operating temperature was 160 to						
	water should be chec Packs." 2. Review of Francis therapy Daily Hydroco April of 2016 indicated recorded temperature Fahrenheit. Review of Daily Hydrocollator Te through April of 2016 74 days the Hydrocol were recorded less th	seit. The temperature of the ked before using the Steam scan Health & Fitness offsite collator Temperature log for d fourteen of fourteen es exceeded 172 degrees of the hospital in-patient emperature log for January indicated at least 27 days of lator recorded temperatures can 160 degrees Fahrenheit.					
	Schedule for the Sab Scrubber indicated th monthly, 100 hours a usage for preventive 4. Review of the doc maintenance (PM) of	er Compact Walk Behind e service schedule required: nd 200 hours operating maintenance.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		005072	B. WING		04	1/20/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AI 1104 E G	DDRESS, CITY, STATE	, ZIP CODE		
FRANCIS	CAN HEALTH RENSSELA	AER. INC	LAER, IN 47978			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S1162	recorded preventative were: 2/2/16, 7/8/15 preventive maintenand documented monthly, maintenance as requiples. Review of Prevent Report stated, "Motor filters replaced, belt to needed." 6. Review of the documented to maintenance (PM) of indicated the previous preventative maintenance (PM) of indicated the previous preventative maintenance and lack maintenance and lack maintenance and lack maintenance inspection. 7. Review of the Clin Maintenance schedul wheelchair located at Fitness offsite and the the Main Entrance of documented preventive. 8. At 10:20 AM on 4/2 (Clinical Engineer) into the preventive have routine inspection. 9. In interview at 1:18 member #1 (Director the above and no othe provided prior to exit. 10. Review of letter respective maintenance of letter respective provided prior to exit.	e maintenance inspections and 7/6/14. The recorded ce inspections lacked and hour usage preventive red by the manufacturer. ive Maintenance Air Handler greased every 6 months, ension, and coils cleaned as umented preventive the Air Handler M12606 ance inspections were: and 4/20/2012. The naintenance inspections emiannual preventive and a preventive con for 2015. ical Engineering Preventive e indicated the one	S1162			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED				
(005072	B. WING		04/20/2016			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FRANCISCAN HEALTH RENSSELAER, INC 1104 E GRACE ST RENSSELAER, IN 47978							
PREFIX (EACH DEFICIENCY MUST B	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMI				
S1162 Continued From page 17 has completed the processing section, the Cryostat is to be tissue/OCT fragments from the Cryostat to include vacuuming the Histovac. 11. Review of patient medical patient: A. 13 underwent a surgical 2/22/16 and a frozen section using the Cryostat. B. 14 underwent a surgical 2/22/16 and a frozen section using the Cryostat. 12. Review of Cryostat main confirmed it was inspected/cl 10/22/15. 13. Staff 10 (Director of Ope Anesthesia Care Unit/Centra Reprocessing/Outpatient Depinterviewed on 4/19/16 at apphours and confirmed Cryostat was last dated 10/22/15 for in cleaning.	cleaned of excess the interior of the ag as needed using all records confirmed procedure on was processed procedure on was processed tenance Logs tenance Logs tenand last on prating Room/Post I Sterile & partment) was proximately 1328 at Maintenance Log	S1162					